8. Sketch a case of "Circular Insanity." What is the prognosis in such a case?
9. Define the following terms:—Delusion, hallucination, illusion, imperative concept.
10. You are called on to give an opinion as to testamentary capacity in a person of advanced age. What indications would guide you in forming the opinion that senile insanity existed?
11. You examine a prisoner committed for an act of violence. Mention the circumstances which would induce you to believe that the person was—(*a*) feigning insanity; (*b*) had acted under insane impulse; (*c*) suffered from transitory insanity; or (*d*) from moral insanity.
12. What is durhœmatoma? In what affections is the condition most commonly found, and what are the theories as to its essential nature?

THE NON-RESTRAINT QUESTION.

We were under the impression that the discussion between Dr. Yellowlees and Dr. Alex. Robertson had exhausted itself in our last number. Each physician had fully and freely expressed his views on a subject in regard to which they honestly hold different opinions. To continue the discussion would, we think, be little more than a repetition of the same statements, if not the same words, without adding any real force to the arguments employed by these able combatants. Dr. Robertson, however, wishes to make it unmistakably clear that he regards "locked gloves" as one form of mechanical restraint. As he places in the same category "side arm dresses" and the "protection bed," and as Dr. Yellowlees recommends their use in exceptional cases, Dr. Robertson maintains that he was not in error in referring to "the considerable use of mechanical restraint" advocated by him. Another statement Dr. Robertson wishes to make, which is, that although he has been connected with an asylum which during the last five years has not had a larger number of patients than 125, it was, during many years previously, licensed for 248 patients, a large proportion of whom were dangerous, both in respect of suicide and homicide.

Correspondence.

TO THE EDITORS OF *The Journal of Mental Science.*

SIRS,—I was unavoidably absent from the Annual Meeting of the Medico-Psychological Association, but have read with great interest in the October number of "The Journal of Mental Science" the very able Address of the President and the subsequent discussion on the subject which is probably uppermost in the minds of all asylum medical officers and others interested in the treatment of insanity at the present moment, viz., the advisability of establishing curative hospitals for occurring cases of insanity and for teaching purposes.

I think the tone in which the President alluded to the misrepresentations in Dr. Batty Tuke's paper in a recent number of the "Nineteenth Century" was most conciliatory; indeed, far too much so, and I was glad to find one or two speakers after him, notably Dr. Clouston, much more decided in disapproval. However, leaving Dr. Batty Tuke to digest the very cogent and wise refutations of his assertions about the total absence of genuine medical spirit in asylums, in the President's Address, I beg to note a few con-

siderations which have occurred to me, and which were not alluded to in the discussion. I would first say that I am young enough not to be "steeped in asylum tradition," and on the other hand, old enough to count over ten years' acquaintance with lunacy work in four English asylums, so that I may be said to approach the subject with an open mind, with ideas uncrystallized by years of routine, yet with experience enough to weigh and criticize existing provisions for the insane and suggested changes therein.

Far too much, I think, has been made of the supposed fact of insanity being an ordinary bodily disease—a disease of the brain, as, say, acute yellow atrophy is of the liver, a disease which can be treated in a hospital ward like any bodily disease; the two are most essentially different and require essentially different provision for their management. To erect hospitals on ordinary or on special hospital lines in London, Birmingham, and other large towns for occurring cases of insanity would, in my opinion, be most prejudicial to the patients in them; it would be impossible to acquire sufficient land for outdoor exercise, work and amusement, which we know to be so beneficial to patients. Prison high walls would be necessary to prevent the patients becoming a shame to themselves and a public nuisance to their neighbours. Moreover, insanity cannot be studied or treated in any such town building; patients cannot, or at all events should not, be submitted to the same methods of examination, or times and places of examination as ordinary hospital patients. I can just fancy a case of acute mania or melancholia being percussed, auscultated, the sphygmograph, thermometer, plethysmograph, etc., used upon him, his history, demeanour, thoughts, habits, delusions, hallucinations all laid bare, probed, and discussed before him at one examination to a crowd of students, and watched incessantly afterwards by "chiels taking notes" of his every word and action. Surely a moment's consideration will bring conviction to the mind that the whole data of mental disease are different from those in bodily diseases, and that lunacy practise cannot, and need not, be conducted on ordinary hospital lines. What the great majority of patients require is letting alone; the very defects in their intellects should not be referred to before them without a sympathetic tact, and he is the best physician to the insane who can by residence among them casually and by degrees ascertain their mental and physical condition, taking part in their work, amusement, and daily life from day to day and month to month. All this is incompatible with the cold-blooded examination of an ordinary hospital patient in a clinical theatre or bedside, which I understand to be the scheme in the suggested teaching hospitals.

Three years ago I read a paper at the Brighton meeting of the British Medical Association at the same time as Dr. Strahan, advocating a curable hospital or block in or near the existing asylums. I advocate this no longer, and further thought and experience have entirely changed my views. Who are to be the inmates of such hospitals? Take a year's admissions to any county asylum and analyze them. We have so many senile cases—these go to an infirmary ward among similar cases; so many congenital cases—these, if children, go to an idiot school ward, if adults, to one of the wards for chronic cases; then the epileptics, who go to an epileptic block; then the bodily-ill, who are located in the hospital ward; then the manifestly chronic delusional and demented cases of long standing, who are sent to appropriate chronic wards. And what have we left? Cases of acute mania with or without general paralysis and acute or recent melancholia, which, after all, are a small proportion of our total admissions, as alone suitable for our suggested hospitals. Apart from the fact that the great majority of such cases recover under present arrangements, it surely cannot be urged, at least in our present state of knowledge or in any at present conceivable advance in knowledge, that the highest general or special medical skill brought to bear on a case of acute mania will prevent it running its course any more than it can prevent the evolution of any acute pneumonia, meningitis or typhoid.

Then consider the inevitable pandemonium from the aggregation in one build-

ing of a great city's acute maniacs, for we must remember complete individual isolation is alike inadvisable and impossible. The melancholia cases, again, of all kinds, from the most suicidal and frenzied to the stuporose hypochondriacal and hysterical, are surely not cases which one would place together either among themselves or within sight or hearing of their friends at the other end of the gamut of mental disorder. Individual attention to the recent or acute cases is a good thing, but with melancholiacs it may be overdone; it has generally been overdone at home before the cases come to the asylum. Nothing so soon restores hypochondriacal, hysterical and self-centred female melancholiacs as to merge their self-important individuality in a well-disciplined ward of 20 or 30 general cases. What more powerful stimulant to healthier thoughts than the example of order, discipline, amusement, or sewing or laundry work, which is all-pervading in any well-managed county asylum? Inveighing as I do against the principle of isolation and separate treatment in general, I readily admit that certain cases are fit and proper ones for individual and separate care, but for this very small proportion I am sure any county asylum could easily devote a room or two from its existing accommodation. Further, while sure of the futility of establishing curable hospitals, and adverse to a selected collection of patients being sacrificed to stock a special teaching hospital, I am not altogether complacently satisfied with existing arrangements. For example, I think the medical staff of an asylum should be more especially skilled. This could be arrived at by appointing as assistants men only who had devoted their time before or after graduation to studies bearing on the specialty—diseases of the brain and nervous system, metaphysics, and also practical and histological pathology. Just as it soon will be illegal to appoint any medical officer of health who does not hold a diploma in State medicine, so it might be made illegal to appoint any asylum medical officer who did not possess some such qualification as our Society's certificate.

Then most men will admit that the nursing in our asylum infirmaries is not at all what it should be. Care and attention, I don't doubt, ensure comfort for our sick; but this is not skill, or at least only a part of it, which should be supplied by trained hospital nurses. Then, structurally, our infirmaries are most defective, even in our modern asylums, and the draughty, ill-ventilated single rooms or dormitories are useless in which to treat pneumonia and similar bodily diseases. Also, I do not think asylum doctors make enough use of the power, set down in most asylum rule-books, possessed by Medical Superintendents, of "calling to their aid any outside medical practitioner." Surely in most towns there are specialists in neurology, surgery, and gynæcology whose aid would be often very valuable. The treatment of insanity in an asylum with these improvements then —coupled with all the usual resources of a county asylum, such as fresh country air and exercise, associated amusements, the benefits of example in workshops, farms, laundries, and sewing rooms, not to mention the opportunities for testing a patient's fitness to resume the ordinary duties of life by trial in a convalescent ward, where there may be but one, or even no attendant—is, I say, to my mind the wisest scheme and the one most conducive to recovery that can be devised.

With regard to teaching medico-psychology, I cannot say I am very sanguine about the benefits to be derived from it. Personally, as a student in Dr. Clouston's class at Morningside, I was intensely interested in the systematic and clinical lectures there given, but—and this may be my own fault—if my knowledge of the subject had ended with the course, I should have known very little about it. Be this as it may, however, I consider no special teaching provision not already available is necessary; every town big enough to have a medical school has one or more asylums in or near it, the heads of which would, I am sure, be most willing and able to give instruction.

The truth is, all this stir about new methods of dealing with the insane arises

from an exaggerated idea of the number of huge asylums which have from time to time to be built. No sooner had the London County Council come to office than they found that their newest and best asylum must be at once enlarged to double its size, and that a large new asylum for 2,000 patients must be built. I fail to see anything alarming in this; population increases, chronics accumulate —had ordinary hospitals to retain their incurables, they would rival public-houses in number—hereditary taint increases insanity with more than arithmetical progression, and after all, we have only about 150 asylums for the mentally unsound of 40,000,000 people.

It is not probable that we can ever diminish the insane by any increase of recoveries; indeed, *the converse is more probable*, but it is conceivable that by improved food, air, dwellings, and knowledge of sociology and hygiene, including temperance and morality, we may *prevent* insanity to a certain extent. All real advance in medicine of solid demonstrable advantage to the community at large has been—as in the case of small-pox and zymotic diseases generally—not so much in the increased cures in individual cases, but in the prevention of their incidence as a whole.

Yours faithfully,
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Medical Superintendent,
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Nov. 7th, 1889.

HYPNOTISM OF THE INSANE.

TO THE EDITORS OF *The Journal of Mental Science.*

SIRS,—I should like, with your permission, to call attention to the dearth of information in respect of attempts to produce the hypnotic state in the insane. At present it is impossible satisfactorily to reply to those who somewhat imperiously demand our adhesion to their *ex cathedra* utterances upon this subject, which they declare to be barren, unprofitable for investigation, and, in short, nonsense. We require definite information, and painstaking inquiry can alone furnish us with such. Experience teaches that it is advisable for the individual operator to limit his attempts to a few patients, repeating them in those patients a reasonable number of times, until he can, with some justice, abandon hope of success. The necessary procedure is, I certainly think, fatiguing, as is any task requiring concentrated attention; hence a great deal cannot be expected of one investigator. But if we could obtain the sum total of the work of numerous investigators, in different asylums, our case would be more presentable. The lead has been taken by Bethlem Hospital, and I believe that an account of the trials there will be published. But I am unaware of other attempts in this country. Briefly, we require to know—(1) Whether an insane person can be hypnotized; (2) If so, is he amenable to suggestions made in the hypnotic state; (3) If so, does he, in the waking state, carry out such suggestions? I observe that Heidenhaim, in the last edition of his work on Hypnotism, quotes a statement of Dr. Jænicke to the effect that "lunatics" cannot be hypnotized. Forel also is mentioned ("Zeitschr. f. Psych") as regarding the "field of psychoses" as "extremely unfavourable" for the therapeutical employment of Suggestion. Binswanger (quoted in the same periodical) considers that attempts on the insane are likely to be productive of "more harm than good." Lastly, Dr. Sperling ("Verhandl. Psychiatr. Vereine")